Call to Order

1. New Business ........................................................................................................ Dr. Gordon

2. ACGME Correspondence ...................................................................................... Dr. Gordon
   A. CLER findings
   B. Email approval of new programs (Adult Congenital Heart Disease, Geriatric Medicine, and Critical Care Medicine)
   C. Approval of New Program Director (George Whitener, MD, CT Anesthesia)

3. Resident Representatives' Report .................................................................. Drs. Ghanim, Hardy, Horton and Sealy

4. Quality Update .................................................................................................. Elizabeth Mack, MD

5. VA Update ......................................................................................................... Terrill Huggins, MD

6. PC Update ......................................................................................................... Melanie Pigott, C-TAGME

7. Program Information
   A. Annual Program Evaluations (APE) ................................................................. Dr. Gordon, MD
      i. Developmental and Behavioral Peds
      ii. Rheumatology
      iii. Peds Emergency Medicine
      iv. Geriatric Psychiatry
      v. Cytopathology
      vi. Hematopathology
   B. Remediations: 2 residents in 2 programs
   C. Duty Hours

8. Old Business
   A. September email voting
      i. Approval of minutes from August 9, 2018
      ii. Approval of Request for New Training Program (Advanced Heart Failure and Transplant Cardiology)
      iii. Approval with condition of funding of Request for New Training Program (Gynecological Oncology)
      iv. Approval of Request for Complement Increase (Neurosurgery)

ANNOUNCEMENTS

Please encourage any of your residents that may be interested in House Staff Council to attend the next meeting on Tuesday, November 13 at 6:00 p.m. in 419 CSB. Any resident/fellow is welcome to attend.

The next Chief Resident/Resident Representative meeting is Wednesday, October 17 at 6:00 a.m. in 419 CSB.

Next GMEC Meeting – Thursday, November 8 at 4:00 p.m. in 628 CSB
August 15, 2018

Ernest B. Clyburn, MD  
Designated Institutional Official  
Medical University of South Carolina  
169 Ashley Avenue, Room 202 Main Hospital  
Charleston, SC 29425

Dear Dr. Clyburn:

On behalf of the CLER team, thank you for your efforts in coordinating your institution’s most recent site visit. Attached is the written report reflecting the team’s findings across the six focus areas.

We offer you the option of submitting a response to be shared with the CLER Evaluation Committee. While the Committee members are open to receiving all manner of feedback, they would especially appreciate any information that would help them to understand how you and the executive leadership of the site visited intend to use the information to improve resident and fellow physician engagement in one or more areas that you have determined to be a priority.

If you would like to respond, please complete the attached form and submit it through ADS on or before 10/05/2018. Once logged into ADS as the DIO, please select the CLER tab, and then under Upload CLER Site Visit Response, select Chose File, then Upload. Please use 11 point font or larger, limit the number of pages to no more than 3 in total, and upload the file as a PDF.

Thank you again for participating in this ongoing process to improve the clinical learning environment. If you have any questions, please let me know.

Best regards,

[Signature]

Robin Wagner, RN, MHSA  
Vice President, CLER
Medical University of South Carolina Medical Center
Clinical Learning Environment Review (CLER)
Site Visit Report

Dates: June 19 - 21, 2018

Sponsoring Institution: Medical University of South Carolina College of Medicine

Participating Site: Medical University of South Carolina Medical Center

Chief Executive Officer (CEO) Host: Patrick Cawley, MD

Designated Institutional Official (DIO) Host: Ernest B. Clyburn, MD

Site Visitors: Robin Dibner, MD (lead site visitor)
               Marian Damewood, MD
               Jill Moormeier, MD (volunteer site visitor)

Overview

The Medical University of South Carolina Medical Center (MUSC) is an acute care academic medical center that sponsors 60 active ACGME-accredited residency and fellowship training programs with just over 700 residents and fellows. The majority of the institution's residency and fellowship training occurs at MUSC Medical Center in Charleston, South Carolina. Their website features their designated cancer center, level I trauma center, and children's hospital. According to their website, MUSC is a key component of the larger integrated health system, MUSC Health, the clinical enterprise of the Medical University of South Carolina including a physicians' group, more than 100 outreach locations, clinical affiliations with numerous health care partners, and a telehealth network.

Methodology

The visit began with a meeting with the CLER team and the institution's senior leadership including Patrick Cawley, MD, CEO; Philip Warr, MD, Interim CMO; Tim Brendle, DNP, RN, Associate CNO; Chris Stern, MD, PGY-3 pediatrics, the resident Graduate Medical Education Committee (GMEC) representative; and Ernest (Ben) Clyburn, MD, the DIO and Chair of the GMEC. Additional activities included group meetings with the senior management of patient safety and health care quality, peer-selected residents and fellows, faculty members, program directors, and a series of one-on-one discussions with individual residents and fellows and other staff (eg, nurses, pharmacists, social workers, technicians) that occurred during the walking rounds of multiple clinical sites within the medical center. As a new part of the site visit, the CLER team met with a group of individuals identified by senior leadership as working to address the well-being of the clinical care team at MUSC.
At the end of the visit, the site visitors met with Dr. Cawley, Dr. Clyburn and other members of the senior leadership team to provide initial feedback on the findings from the visit.

Group meetings with the residents and fellows, faculty members, and program directors included a combination of closed- and open-ended questions on topics in the CLER focus areas. An electronic audience response system was used to collect anonymous responses to multiple-choice questions.

The walking rounds helped to expand or clarify information on some of the topics raised during the group meetings. The CLER team visited more than 25 clinical locations, including medical and medical specialty, surgical and surgical specialty, pediatric, obstetric, psychiatric, perioperative, procedural, and intensive care units; the radiology department; the pathology department; the pharmacy department; the emergency department; and ambulatory care sites. The team observed 6 resident and fellow change-of-shift hand-offs.

This report presents the results from the audience response system as percentages. In the group meetings, the CLER team interviewed 56 residents and fellows, 45 faculty members, and 47 program directors from the residency and fellowship programs at MUSC. Although, overall, the response rate was high (>95%) for all questions, the number of respondents for any single question may have varied. Of the resident and fellow cohort, none were postgraduate year (PGY)-1, 25% were PGY-2, 25% were PGY-3, and the rest were PGY-4 or higher. Sixty-two percent of the faculty members and 77% of the program directors interviewed indicated that they had been at MUSC for 6 or more years.

The results from the audience response system are included for the purposes of providing general feedback. Those interviewed did not comprise a random sample. This report includes point estimates only and not estimates of variance (e.g., confidence intervals). In addition, this report uses the following summary terms to summarize the results from the audience response system: few (<10%), some (10%-49%), most (50%-90%), and nearly all (>90%).

The site visit explored 6 areas of focus: patient safety, health care quality (with a special focus on health care disparities), supervision, care transitions, well-being, and professionalism. The site visit is structured to assess the focus areas as they relate to (1) institutional infrastructure and resources, (2) graduate medical education (GME) leadership and faculty members’ engagement, (3) resident and fellow engagement, (4) the medical center’s perspective on their measures of success in integrating GME into their infrastructure to address patient safety and quality, and (5) the medical center’s plans for improving the clinical learning environment in these 6 focus areas.
Initiatives in the Clinical Learning Environment

At the meetings with senior leadership, the patient safety and quality leaders, and the program directors, the CLER team explored the medical center’s efforts to integrate GME in supporting the organization’s strategic goals to improve patient care, changes made since the last CLER visit, and challenges in the focus areas.

When asked how GME has been integrated into MUSC’s key strategic initiatives, Dr. Cawley noted that, last year, residents and fellows provided input into the development of the strategic plan. He also noted the prominent role of residents and fellows in many patient safety and quality initiatives and on medical center committees.

The patient safety and quality leadership team noted a number of special efforts to educate the residents and fellows on the medical center’s strategic plan and priorities in patient safety and quality improvement (QI). These include presenting at orientation, monthly meetings with the chief residents, individual program presentations and reviews of reported patient safety events, and the efforts of the GME Medical Director of Quality who presents at the GMEC.

When asked how residents and fellows are involved in developing MUSC’s patient safety and QI strategy, the patient safety and quality leadership team indicated residents and fellows are not involved in strategic planning for QI. They noted that residents and fellows serve an important role in implementing medical center-wide initiatives and that resident and fellow feedback from the culture of safety survey helps to determine the goals and objectives of the strategic plan.

The senior leadership team indicated that since the last CLER visit, of the CLER focus areas, the medical center has made the most progress in addressing well-being. Senior leadership identified transitions of care as posing the greatest challenge. In explaining the challenges, the senior leadership team mentioned the challenges of transitioning patients to follow up in their home communities, especially in smaller towns and rural areas.

Program directors described efforts to improve the clinical learning environment since the last CLER visit, such as a revision of the funding process for GME program leadership, increased resident and fellow involvement in QI projects, increased awareness of fatigue and burnout by residents and faculty members, and increased patient safety event reporting. They also described program-specific goals in the CLER focus areas and progress in accomplishing these goals, including responding to the risk of burnout by providing education and adding ancillary clinical help; developing departmental quality and patient safety committees; joining the national I-PASS initiative; and starting a resident wellness committee which is being expanded to faculty members.

The residents and fellows interviewed were positive when speaking about the clinical and educational culture at the medical center. Many of the nurses interviewed indicated that working with residents and fellows is a rewarding experience.
Patient Safety

The CLER team explored several areas of patient safety, including use of the patient safety event reporting system, feedback on patient safety event reports, inclusion in patient safety event investigations, and the clinical learning environment's role in monitoring patient safety.

Use of the Patient Safety Event Reporting System

The patient safety and quality leaders noted that MUSC uses an online system for reporting patient safety events and indicated that the system allows for anonymous reporting. They noted that MUSC has expanded requirements for resident and fellow reporting to include reviews and suggest improvements on the events they report. The patient safety and quality leaders mentioned that residents, fellows, and faculty members can also submit patient safety event reports by calling a hotline, using the chain of command, or reporting directly to the patient safety office. They noted that their staff subsequently enter any reports received through these mechanisms into the online system.

The patient safety leadership team indicated although they do not have specific goals for resident and fellow recognition and reporting of adverse events, near misses, and unsafe conditions, they are monitoring for an annual increase in the absolute number and proportion of the total reports submitted by residents and fellows compared with the prior year, and noted they have observed this increase since instituting a resident incentive program.

The patient safety and quality leaders reported that in calendar year 2017, MUSC received 16,086 patient safety event reports. Of these, 161 were submitted anonymously, residents and fellows submitted 1,540 reports and medical staff physicians submitted 402 reports.

In the group meetings, 49% of the faculty members and 69% of the program directors indicated that, in the past 12 months, they had personally reported a patient safety event at MUSC using the medical center's patient safety event reporting system.

In the group interviews, 98% of the residents and fellows indicated that they believe the medical center provides a supportive, nonpunitive environment for reporting patient safety events. The high proportion of resident and fellow reports into the medical center's patient safety event reporting system supports their view of a nonpunitive system.

In the group interviews, 88% of the residents and fellows reported that they had experienced an adverse event, near miss, or unsafe condition while at MUSC. Of these, 82% (72% of the total) indicated that they had personally entered the patient safety event into the medical center's patient safety event reporting system, 4% indicated that they relied on a nurse to report the patient safety event, 8% indicated that they relied on a supervisor to report the patient safety event, and 6% indicated that they chose not to report the patient safety event. In a separate query, 55% of the residents and fellows indicated that they have reported a near miss at MUSC in the past year.
When the faculty members and program directors in the group sessions were asked what process they believe their residents and fellows follow when reporting a patient safety event, 93% of the faculty members and 85% of the program directors responded that they believe their residents and fellows report the patient safety event using the medical center’s patient safety event reporting system.

All residents and fellows interviewed on walking rounds stated that they had entered a patient safety event into the medical center’s patient safety event reporting system. Many residents and fellows appeared to have an understanding of the range of reportable patient safety events, including near misses, unsafe conditions, and events without harm; fewer appeared to recognize unexpected deteriorations and known complications of procedures as reportable patient safety events. They appeared to understand their responsibility to report patient safety events into the medical center’s central patient safety event reporting system and appeared to understand how reporting of patient safety events can provide opportunities to identify potential causes of harm and promote improvements to prevent future patient safety events.

The CLER team also asked nurses about their use of the patient safety event reporting system. The nurses interviewed on the walking rounds appeared to be familiar with the medical center’s patient safety event reporting system. A small proportion had not submitted a patient safety event report in 6 months or longer.

Many nurses interviewed appeared to recognize near misses, unsafe conditions, events without harm as reportable. Fewer recognized unexpected deteriorations or known complications of procedures as reportable patient safety events. Some noted that known complications of procedures are tracked within their units for discussion or at M&M conferences and may not be entered into the patient safety event reporting system. Nurses in some clinical areas noted the amount of time needed to enter a patient safety event report, competing clinical responsibilities, and lack of feedback limited their reporting of near misses or less serious patient safety events.

Several residents, fellows, and nurses interviewed across multiple service areas on walking rounds indicated that the medical center’s patient safety event reporting system was occasionally used to report on the behaviors of others. They patient safety leadership indicated that they have encouraged the use of the system to report behaviors and professionalism issues that may undermine the culture of safety.

**Feedback on Patient Safety Event Reports**

Of the residents and fellows in the group interviews who indicated that they had reported a patient safety event by any means (themselves or through a nurse or physician supervisor), 61% indicated that they had received feedback on the outcome of the report. When asked to describe, residents and fellows noted they received an email indicating that a case has been closed and instructions on how they may follow up to obtain more information. Others noted participation in RCAs and departmental conferences that provide feedback regarding major events, or phone calls from risk management or an attending physician. Faculty members and
program directors indicated that residents and fellows also learn about the outcome of their reports by participating in departmental morbidity and mortality (M&M) conferences or other case-based discussions, the children's hospital event review meetings, and through feedback from the risk management department to the departmental patient safety liaisons.

**Inclusion in Patient Safety Event Investigations**

The patient safety leadership team reported that they conducted 49 patient safety event investigations called serious safety solutions (S3s) in calendar year 2017. They indicated that 35 residents and fellows had participated in one or more of these investigations. They also noted that the medical center conducted 321 other types of investigations for low harm events or those that did not reach the patients, and noted they do not track resident and fellow participation in these investigations.

During the group sessions, the CLER team asked residents, fellows, and program directors about their participation in patient safety event investigations such as root cause analyses (RCAs) that included the following five components:

- Review by an interprofessional team
- Detailed analysis of patient safety event–related systems and processes
- Identification of potential systems changes
- Implementation of an action plan
- Follow-up evaluation of the actions

Of the residents and fellows in the group who were PGY-3 and above, 65% indicated that they had participated in an interprofessional investigation of a patient safety event (eg, RCA). When asked to describe their experience, several noted participating in a process that included the steps of a formal investigation that would allow them to understand a systems approach to addressing factors associated with adverse events, near misses, and unsafe conditions.

Fifty-eight percent of the program directors interviewed indicated that they had participated in a patient safety event investigation led by the medical center.

When asked about the ways that residents and fellows experience interprofessional patient safety event investigations, program directors provided the following examples: RCAs, mock RCAs, departmental M&M conferences, patient safety event reviews, and quality conferences. Based on their descriptions of these conferences, programs and departments appeared to vary in their approaches to teaching how to conduct these types of investigations.

In the interviews on walking rounds, residents and fellows appeared to vary in their understanding of patient safety principles, methods, and tools (eg, Swiss cheese model of system failure, fishbone diagrams) associated with a systems approach to investigating adverse events, near misses/close calls, or unsafe conditions. Several residents and fellows appeared to
be conversant with these concepts. The level of understanding appeared to vary across programs.

Sharing Lessons From Patient Safety Event Reports and Investigations

The patient safety and quality leadership team stated that they share the numbers of patient safety event reports submitted by residents, fellows, and medical staff physicians at the GMEC monthly meeting as a standing agenda item presented by the GME medical director of quality. They also indicated that they report the numbers of residents and fellows who have participated in patient safety event investigations to the GMEC. They indicated they do not report the number of resident and fellow patient safety event reports or participation in patient safety investigations to the medical center’s governing body. They noted that MUSC is a state institution and that the meetings are open to the public.

The patient safety and quality leadership team stated that efforts to disseminate lessons learned from patient safety event investigations to the residents and fellows include a weekly update dedicated to lessons learned which is included in a daily safety email sent to residents, fellows, faculty members and other members of the clinical care teams.

The CLER team also explored issues around disclosure of patient safety events. During the group interviews, 84% of the residents and fellows reported that they have received training on how to disclose medical errors to patients and families; 5% responded that the question was “not applicable” to their specialty. Of those who indicated they had received training, 25% indicated that the training was principally provided by lecture; 37%, online; 4%, via simulation; and 31%, informally while providing care.

When given a scenario of being involved in a major patient safety event resulting in a patient death, 80% of the residents and fellows in the group interviews indicated that they know of medical center resources to assist them in coping with the event. Of the residents and fellows familiar with the resources, 78% indicated that they would be somewhat or very comfortable using these resources.

Procedure Management

The CLER team also explored resident and fellow management of bedside and ambulatory procedures. The nurses, residents, and fellows interviewed on walking rounds indicated that the residents and fellows, faculty members, attending physicians, and consultants are actively engaged in the process of performing a time-out before bedside and ambulatory procedures. Nurses reported that if a physician does not perform a standardized time-out, they feel comfortable to speak up and the procedure is stopped. A few nurses noted that they are not routinely involved in bedside procedures performed on their unit.
Suggestions for Improving Resident and Fellow Training in Patient Safety

When asked for suggestions to improve resident and fellow training in patient safety, faculty members and program directors recommended interdisciplinary or system-wide M&Ms.

Health Care Quality

Priorities in Health Care Quality

The members of the senior leadership team stated that the medical center's top priorities for improving health care quality are to promote patient safety event reporting and further develop the system of interprofessional quality and performance improvement plans (QAPs) in each of the integrated clinical centers of excellence (ICCEs, previously service lines) to decentralize the management of quality.

In the group meetings, 80% of the residents and fellows, 80% of the faculty members, and 77% of the program directors reported knowing MUSC's QI priorities. Overall, residents, fellows, faculty members, and program directors described priorities that did not specifically align with those mentioned by senior leadership. They principally mentioned clinical quality metrics such as hospital acquired conditions.

Engagement in Quality Improvement Activities

The patient safety and quality leaders indicated the medical center uses IMPROVE (Identify the problem, Measure the impact, Problem analysis, Remedy selection, Operationalize the remedies, Validate the improvements, Evaluate over time) in designing and implementing QI activities.

In the group discussion and on walking rounds, a limited number of the residents and fellows appeared to be familiar with QI terminology and processes. In general, the residents and fellows were able to describe how QI processes would be used to improve patient care.

When the program directors were asked about their experience with QI processes and methods in place at MUSC, 23% indicated that they had extensive experience in using these QI processes and methods, 85% indicated that they had moderate experience, and 12% indicated they had minimal or no experience.

The patient safety and quality leadership stated that their department does not have a mechanism to centrally monitor resident- and fellow-led QI projects.

Of the residents and fellows in the group interviews who were PGY-2 and above, 88% indicated that they have participated in a QI project of their own design or one designed by their program or department. Of those, 71% indicated that the project directly linked to one or more of the
medical center's goals, 6% indicated that the project did not link to the medical center's goals, and 23% responded that they did not know if the project linked to the medical center's goals.

When asked to describe their involvement in QI projects, residents and fellows in the group interviews and on walking rounds described planning and/or implementing an activity, developing order sets or clinical process changes, program-level educational activities, or compliance with clinical guidelines. Several described projects that included the steps of evaluating the efforts; a limited number described projects with follow-up actions to support ongoing improvement or projects with more than one cycle of improvement.

A limited number of the nurses interviewed on walking rounds indicated that they were working on interprofessional QI projects that included residents or fellows.

The patient safety and quality leadership team indicated that residents and fellows share the lessons learned from their QI projects with other professions across the organization by displaying their QI projects as posters during patient safety week.

Access to Data

Eighty-one percent of the program directors in the group interviews reported that their residents and fellows have ready access to organized systems for collecting and analyzing data for the purposes of QI. When asked to provide some examples of these resources, program directors mentioned the electronic health record, departmental databases, and local, regional, and national registries.

The patient safety and quality leaders indicated that residents and fellows may obtain quality performance data specific to their patients by using specific functions in the EHR. They noted that a few departments are able to provide individual data from specialty-specific data bases. Program directors in some programs confirmed that they have recently been able to provide individual resident or fellow level data from the EHR.

In response to a question about access to data directly related to their patients, 5% of the residents and fellows in the group interviews indicated that they periodically receive QI data on their own patients, and 25% indicated that they periodically receive both data on their own patients and data related to patients in their department or service area. Thirty-nine percent reported that they only receive aggregated or benchmarked QI data related to patients in their department or service area, and 30% indicated that they do not receive any aggregated or benchmarked QI data related to patient care.

Suggestions for Improving Resident and Fellow Engagement in Quality Improvement

Residents, fellows, faculty members, and program directors offered several recommendations to improve resident and fellow engagement in MUSC's QI initiatives. Residents and fellows recommended, for example, consolidating multiple related QI efforts into one large project in
some departments, and providing protected time for QI projects. Faculty members and program directors suggested increasing support for data collection, analysis, publication, and presentation of resident and fellow QI projects; making quality data available at the individual resident or fellow level; including outpatient areas in QI work; and developing a QI track within training programs.

Health Care Disparities

Patient Populations at Risk for Health Care Disparities

When asked to describe the patients receiving care at MUSC at risk for health care disparities, residents and fellows mentioned patients who are non-English speaking, patients who are LGBT, those who are uninsured, patients of different cultural backgrounds, and those of low socio-economic status. Faculty members and program directors added patients who are hearing impaired, patients with low health literacy, and patients with HIV. They also mentioned pediatric patients transitioning to adult medicine, transgender youth, and patients who live in rural areas as populations at risk for health care disparities.

In the group meetings, 34% of the residents and fellows and 55% of the faculty members indicated that, while at MUSC, they have participated in cultural competency training specific to the patients receiving care at the medical center. During the interviews on walking rounds, the majority of residents, fellows, and nurses described cultural competency training that appeared to be largely generic.

Resident and Fellow Engagement in Efforts to Eliminate Health Care Disparities

Four percent of the residents and fellows in the group interviews indicated that they had participated in a QI project focused on eliminating health care disparities at MUSC.

Faculty members and program directors noted that resident and fellow engagement in advancing efforts to eliminate health care disparities at MUSC includes the following examples: providing hands-on clinical care in undeserved and/or rural areas, telemedicine care, facilitating enrollment of rural and minority patients in clinical trials, and involvement in research projects.

Clinical Site Efforts to Eliminate Health Care Disparities

The senior leadership team indicated that MUSC’s efforts to eliminate disparities in health care among the patients receiving care at the medical center include a strategic focus on diversity, inclusion, and health and healthcare disparities. They noted that they are in the early phases of building awareness of healthcare disparities and have instituted implicit bias training. They described that they are currently analyzing internal data to identify where care disparities may exist, and then assigning performance improvement teams to areas of concern.
When asked about measures that focus on health care disparities as part of the medical center's performance measurement tools for tracking quality and patient safety, the senior leadership team indicated that the medical center does not currently have measures that focus on health care disparities. They noted their use of Vizient data as a source of information which has resulted in efforts to improve in a few identified areas of disparities in care. (eg racial differences in ED length of stay prior to admission).

The CLER team asked the patient safety and quality leadership team if they report quality metrics to the medical center's governing body by subgroups of vulnerable populations. They indicated that they do not currently report by subgroups.

In the group meetings, 22% of the residents and fellows, 42% of the faculty members, and 35% of the program directors reported that they were aware of QI performance measures that the medical center uses to assess its efforts to eliminate health care disparities. Examples included tracking utilization of translation services, patient satisfaction scores, the children's hospital's participation in a national collaborative addressing healthcare disparities, and annual program evaluation reports to GME leadership.

MUSC appears to be in the early stages of developing a systematic approach to identifying variability in the care provided to or the clinical outcomes of their known vulnerable patient populations that includes the steps of periodic review of performance measures to identify disparities in patient care or outcomes, targeted QI efforts to address these disparities, and ongoing analyses to assess these efforts.

Senior leadership also noted that some departments and service lines are conducting population-specific studies or research projects related to health care disparities.

Care Transitions

Education on Care Transitions

Sixty percent of the residents and fellows in the group interviews indicated that, while at MUSC, they have participated in formal interprofessional educational activities focused on patient care transitions. When asked for examples, residents and fellows described departmental educational activities for physicians aimed at improving hand-off skills; a limited number described interprofessional educational activities aimed at improving hand-off skills when communicating with all members of the care team.

The CLER team also asked the program directors about resident and fellow participation in interprofessional training on transitions in care. Fifty percent of the program directors reported that their residents and fellows participated in team training that involved nurses and other health care professionals.
Engagement in and Assessing Care Transitions

When asked about transitions at discharge, 23% of the residents and fellows in the group interviews reported that they follow a standardized process for handling transitions from inpatient to outpatient care. Thirty-eight percent responded that the question did not apply to their specialty.

Sixty-four percent of the residents and fellows in the group interviews indicated that they follow a standardized process for handling transitions of care during hand-offs between shifts. Fourteen percent indicated this does apply to their specialty. Of those who indicated they followed a standardized process, 75% indicated that they use a standardized written template for communication to facilitate the hand-off process. When asked how frequently attending physicians supervise their shift-to-shift hand-off process, 18% of the residents and fellows responded that attending physicians supervise daily, 7% responded at least once per week, 9% responded at least once per month, and 45% responded rarely. Twenty-one percent of the residents and fellows responded that the question did not apply to their specialty.

Seventy-five percent of the faculty members in the group interviews indicated that they assess resident and fellow readiness to move from direct to indirect supervision in conducting change-of-shift hand-offs. Fifty-four percent of the program directors indicated that their program assesses resident and fellow readiness to move from direct to indirect faculty supervision in conducting change-of-shift hand-offs. Of these, 7% indicated that their programs directly observe using a standardized assessment tool to monitor resident and fellow change-of-shift hand-offs.

During the walking rounds, the CLER team observed change-of-shift hand-offs for 6 clinical services. Across services, these hand-offs were consistent with regard to being held in quiet, nonpatient areas with minimal interruptions. The majority of the observed hand-offs were supervised by engaged senior residents; used standardized written templates, contingency planning (if/then scenarios), and synthesis by the receiver that included asking questions and confirming the plan of care.

Perceived Vulnerabilities in Care Transitions

In group discussion and on walking rounds, residents, fellows, and nurses interviewed expressed their belief that the transitions at MUSC posing the greatest risk for patient safety due to incomplete or inaccurate communication include transfers from the intensive care units to the floors, transfers from the floors or ORs to ICUs, and transfers from inpatient to outpatient care. They also mentioned patient transfers from other facilities that arrive unannounced or with incomplete or inaccurate information including imaging studies that cannot be opened; delays in patient care when beds are unavailable for emergency department patients admitted to inpatient care; hand-offs after extended shifts; ED to ED transfers; and the transition from pediatric to adult medicine care.
The patient safety and quality leadership team noted efforts to improve transitions in care at MUSC, including developing embedded hand-off tools and an interprofessional discharge planning document in the EHR. The patient safety and quality leadership team indicated that they monitor resident and fellow transitions of care for issues regarding patient safety by auditing medication reconciliation documentation on admission and at discharge.

Supervision

**Perceived Vulnerabilities Related to Supervision**

When asked about patient safety vulnerabilities related to resident and fellow supervision at MUSC, the senior leadership team did not express specific concerns.

The CLER team also asked faculty members and program directors about perceived patient safety vulnerabilities related to resident and fellow supervision. They identified that for some inpatient services, no in-house attending physician is present on nights or weekends. They also noted that residents and fellows vary in their comfort level and/or decision processes in determining when to ask for assistance; a faculty member may be placed in a situation where they are expected to supervise residents in two distant parts of the hospital; and productivity pressures may impact faculty members’ availability to supervise. Some expressed the concern that residents and fellows are oversupervised, leaving them potentially unprepared for independent practice.

To address some of these supervision concerns, program directors noted that the medical center has implemented a GME funding model which takes teaching time into account.

**Perceptions of Supervision**

When the CLER team asked the residents and fellows in the group interviews to characterize their experience with supervision at MUSC, 2% responded that they are generally undersupervised, 7% responded that they are occasionally undersupervised, 68% responded that they are adequately supervised, 20% responded that they are occasionally oversupervised, and 4% responded that they are generally oversupervised.

When the program directors were asked the same question, 15% indicated that the residents and fellows are generally oversupervised, 23% indicated that the residents and fellows are occasionally oversupervised, 58% indicated that the residents and fellows are adequately supervised, and 4% indicated that the residents and fellows are occasionally undersupervised.

During the group interviews with residents and fellows, 29% indicated that while training at MUSC, they have been placed in a situation or witnessed one of their peers in a situation where they believed supervision was inadequate. Residents and fellows explained that the general situations in which this occurred involved difficulties in locating the attending, contacting on call
physicians at night, and attending physicians that were not be immediately proximate when an emergency situation occurred.

When asked to describe their experience with contacting attending physicians and consultants for help at MUSC, 34% of the residents and fellows in the group interviews reported that they have occasionally encountered a physician who has made them feel uncomfortable about asking for assistance; 7% indicated that they have frequently encountered a physician who has made them feel uncomfortable about asking for assistance.

The CLER team also asked the program directors about their opinions on the experience of residents and fellows with requesting assistance. Forty-two percent of the program directors expressed the belief that residents and fellows have occasionally encountered a physician who has made them feel uncomfortable about asking for assistance. None expressed the belief that residents and fellows have frequently encountered a physician who has made them feel uncomfortable about asking for assistance.

Clinical Learning Environment Monitoring of Resident and Fellow Procedural Supervision

Eighty-six percent of the residents and fellows in the group interviews indicated that they know what they are allowed to do without direct supervision. When asked about residents and fellows from other services performing clinical procedures on their patients, 29% of the residents and fellows responded that they have an objective way to verify what procedures their peers are allowed to do without direct supervision.

In the group interviews with the faculty members, 80% indicated that they have an objective way to know which procedures a particular resident or fellow is allowed to perform without direct supervision. Faculty members noted that the GME office has an online system that allows them access to information about procedural supervision requirements for all residents and fellows in all programs. Faculty members and program directors noted that the online system is also available to nurses.

The patient safety and quality leadership team indicated that they do not monitor whether the database/system is being used by the physician staff and other members of the health care team in the course of patient care.

In the interviews on walking rounds, the majority of nurses were aware of the online system for accessing information regarding which procedures a resident or fellow is allowed to do without direct supervision. A small proportion of the nurses indicated that they had accessed the system in the past year. When asked to demonstrate use of the system, the majority of nurses could reach the site; a limited number were able to log on and access the procedural supervision requirements. The majority of nurses interviewed indicated that, in the absence of an attending physician, they principally rely on familiarity, trust, year of training, or assume or confirm the attending physician has given permission for the resident or fellow to perform the bedside patient procedure.
Nineteen percent of the program directors interviewed reported that, in the past year, they have had to manage an issue of resident or fellow supervision that resulted in a patient safety event. The patient safety and quality leadership did not recall any patient safety event reports involving issues of resident or fellow supervision.

**Well-Being**

As part of this round of visits, the CLER team explored a selected set of interrelated topics in well-being: work/life balance, fatigue, burnout, and support of those at risk of or demonstrating self-harm. This focus area replaces what was formerly called “duty hours, fatigue management, and mitigation.”

*Promoting the Well-Being of the Clinical Care Team*

Based on conversations with the senior leadership team, it appears that MUSC has a strategy that supports the well-being of the clinical care team. They noted that is a specific goal in their strategic plan. They described that the most recent quarterly leadership institute, attended by more than 500 leaders and managers, was devoted to well-being and burnout, and focused on identification and interventions. Members of the senior leadership team mentioned that the top priority in this area is developing awareness of well-being issues in the medical center, emphasizing the need for identification of burnout, and publicizing available resources.

The well-being representatives stated that MUSC maintains several activities and programs to promote the physical and emotional well-being of residents and fellows, such as group social activities, free wellness center/gym memberships for residents and fellows, women’s support groups, and other residency and fellowship program based activities.

Eighty percent of the faculty members in the group interviews reported that they knew of programs that MUSC maintains to support their well-being. They mentioned, for example, GME and university sponsored programs on stress and burnout, a wellness center, and online and live didactics that address wellness topics.

*Workload and Work/Life Balance*

In the section that follows, workload refers to volume and complexity of patient care, as well as hours worked, including documentation, research, and educational activities.

Based on conversations with the senior leadership team and the well-being representatives, it does not appear that MUSC sets specific expectations for faculty workload to promote safe and high-quality patient care. When asked how the medical center monitors whether faculty members exceed expected workload, the well-being representatives mentioned that chairs evaluate RVU productivity status and would be alerted by evidence of excessive clinical productivity.
In the group meetings, 65% of the faculty members and 23% of the program directors agreed or strongly agreed that the medical center creates an environment that promotes balance between faculty workload and their well-being.

When asked how MUSC monitors whether faculty’s clinical workload adversely affects teaching responsibilities, the senior leadership team noted use of the resident ACGME surveys.

In the group meetings, 38% of the faculty members and 81% of the program directors agreed or strongly agreed that the volume and intensity of faculty member's clinical workload adversely impacts their ability to teach residents and fellows.

Fifteen percent of the program directors reported that the medical center’s leadership collaborates to a moderate or great extent with GME leadership to set expectations for resident and fellow workload to optimize patient care while supporting their well-being. When asked to describe how these expectations are set, they mentioned DIO discussions with the CEO and Dean, and hiring of hospitalists and advanced practice providers (APPs) to reduce resident and fellow clinical workload.

The patient safety and quality leadership indicated that they assess for risks to patient safety due to resident and fellow workload and use this information to reduce risks to patients through review of patient safety event reports and issues raised during patient safety investigations.

When asked how the medical center addresses concerns about patient safety related to staff workload, residents, fellows, nurses interviewed in the group meeting and on walking rounds mentioned surge coverage in some residency programs and clinical units.

**Fatigue**

Eighty-six percent of the residents and fellows in the group interviews agreed or strongly agreed that the medical center has successful systems in place to ensure patient safety from the risks of resident and fellow fatigue.

In the interviews on walking rounds, residents, fellows, nurses indicated that they were aware of medical center efforts at their program or unit level to proactively recognize and address fatigue among the clinical care team.

The residents and fellows in the group interviews were presented with a scenario in which they are maximally fatigued, yet have 2 hours remaining until the end of their shift. When asked what they would do in this circumstance, 55% of the residents and fellows indicated that they would power through to hand-off; 14% indicated that they would approach another resident or fellow and hope he/she would take over their responsibilities; 16% indicated that they would notify a supervisor and expect to be taken off duty immediately; 14% responded “other” with some suggesting that they would ask to share the workload with a peer or ask the resident scheduled for the next shift to come in earlier.
When the faculty members and program directors were given the same scenario, 21% of the faculty members and 12% of the program directors expressed the belief that the resident or fellow would power through to hand-off, whereas 60% of the faculty members and 62% of the program directors expressed the belief that the resident or fellow would notify a supervisor and expect to be taken off duty immediately.

The well-being representatives noted that MUSC assesses the effectiveness of its efforts to manage fatigue among the clinical care team by faculty surveys and measuring staff turnover. They noted current pilot studies that include assessments of effectiveness of programs that promote healthy lifestyles.

During the group interviews, program directors offered several suggestions on how the medical center could further help residents and fellows minimize fatigue while on duty, including reducing the burden of non-physician tasks, developing policies to address times of surge capacity at the hospital, hiring more APPs, and developing attending-only services. They also emphasized the importance of access to healthy food options 24/7 for residents, fellows, and faculty members and noted that long wait times in the cafeteria discourage eating when a short break is available.

**Burnout**

Based on conversations with the senior leadership team, MUSC appears to have systems in place to identify the level of burnout among faculty members that includes surveys administered in most departments. They noted that the data are shared with chairs and division directors.

The well-being representatives described the following efforts to build awareness of burnout at MUSC: the recent leadership development institute program, a new interprofessional task force to address clinician burnout and methods to build resilience, a faculty round table presentation on burnout, and EAP presentations at the department level for residents, fellows and faculty members to address recognition of burnout and available resources.

In the group sessions, 57% of the residents and fellows and 75% of the faculty members reported that they are moderately or very prepared to recognize and respond to burnout among the members of the clinical care team.

When the CLER team asked the residents and fellows how frequently they see signs of burnout among the faculty members at MUSC, 38% responded sometimes and 25% responded often. When asked the same question, 52% of the faculty members reported they sometimes see signs of burnout among their faculty colleagues; 20% reported often.

In the group discussion and interviews on walking rounds, the CLER team asked residents, fellows, nurses, about their observations of signs of burnout among members of the clinical care team. Those who indicated that they had witnessed signs described faculty members arriving late, expressing frustration with ancillary and support staff, as well as with clinical inefficiencies
and the EHR; showing decreased interest in clinical teaching and engagement in clinical care; having an increased focus on RVUs and productivity; losing empathy toward patients; and attrition.

**Support of Those at Risk of or Demonstrating Self-Harm**

When asked about the medical center's process to identify residents, fellows, and faculty members at risk of or demonstrating self-harm, the well-being representatives did not describe a consistent process to identify these individuals. They indicated that once an at-risk individual is identified there are a number of referral options immediately available: EAP, forensic psychiatry consultation, and/or referral to the impaired physician program. The well-being representatives noted that the medical center assesses the effectiveness of its efforts to facilitate care for those at risk of or demonstrating self-harm through ongoing monitoring after their return to the medical center and ultimate success in their career as tracked by resident and fellow graduate surveys.

In the group sessions, 48% of the residents and fellows, 68% of the faculty members, and 85% of the program directors reported that they are moderately or very prepared to recognize members of the clinical care team at risk of or demonstrating self-harm.

In a follow-up question, the CLER team asked the groups of residents and fellows, and program directors what they would do if they identified a member of the clinical care team at risk of or demonstrating self-harm. Residents and fellows indicated that for a colleague they would speak directly with the individual first, and then the chief resident or program director. If a faculty member, they would bring this to the attention of the program director or chair. For a nurse they would approach the charge nurse or the nursing supervisor. Program directors noted similar approaches and added that for residents and fellows, they would remove the individual from clinical duties and facilitate an emergency safety assessment. For a peer or a nurse they would refer to EAP.

The CLER team asked the residents, fellows, and faculty members if they knew of resources offered by the medical center to support their well-being if they needed personal or professional support after one of their colleagues harmed him/herself. Eighty-two percent of the residents and fellows and 84% of the faculty members reported that they knew of these resources.

**Future Well-Being Efforts**

The CLER team asked the well-being representatives about their vision of the future of well-being efforts at MUSC. They expressed a vision to integrate the well-being strategy and associated activities across the three entities that make up MUSC (medical center, physician's group, and the College of Medicine). They also noted the importance of effectively communicating the availability and accessibility of the many well-being resources and support services to all constituents at MUSC.
Professionalism

During the visit, the CLER team touched on a selected set of topics related to professionalism, including honesty in reporting, integrity, and mistreatment.

Current Challenges Regarding Professionalism

The senior leadership team noted that the major challenges regarding unprofessional behavior at MUSC are episodes of unprofessional behavior that are not addressed immediately or repeated behaviors that are not escalated quickly. They indicated that MUSC is addressing these challenges by promoting a just culture and exhibiting a low tolerance for unprofessional behavior in all settings.

Honesty in Reporting

In the group meetings, 34% of the residents and fellows and 16% of the faculty members indicated that they have documented a history or physical finding in a patient medical record that they did not personally elicit without documenting the original source (such as copying and pasting from another note without attribution).

To explore the medical center’s culture around reporting of duty hours, the CLER team presented a scenario to the residents and fellows in the group interviews in which a colleague stays 30 minutes beyond his/her duty hours limit to address a nonurgent clinical task. When asked whether the colleague would report the time, 82% responded that it was somewhat or very unlikely that the colleague would do so. The CLER team also presented the same scenario to the program directors and 12% reported that it was somewhat or very unlikely that the resident or fellow would report the time.

Integrity

The CLER team asked the residents and fellows in the group interviews how often faculty members disclose whether or not they have potential conflicts of interest at the beginning of all medical education conferences. Sixty-three percent indicated that faculty members always report such potential conflicts.

When asked how often faculty members disclose whether or not they have potential conflicts of interest during each resident and fellow clinical rotation, 11% of the residents and fellows reported that faculty members always disclose this information.

To further explore issues of integrity, the residents and fellows in the group interviews responded to a scenario in which one of their colleagues has written a manuscript and the department chair, although not involved in the project, asks to be included as an author. When asked what they would advise the colleague to do, residents and fellows responded as follows: 36%, include the chair’s name on the manuscript; 45%, discuss the request with the CMO, DIO,
or a faculty member; none, register a concern with the ACGME; and 20%, "other." Of those who responded "other," some indicated they would advise speaking with the chair directly, submitting the paper without putting the chair's name on the manuscript, or publishing the paper after graduation.

In the group interviews, 13% of the residents and fellows reported that there had been at least one occasion where they felt pressured to compromise their integrity to satisfy an authority figure while at MUSC.

**Respectful Treatment of Others**

Overall, the majority of the residents, fellows, nurses, and other health care professionals interviewed indicated that they work in a respectful environment. However, individuals across several areas of the medical center described the behavior of a few attending physicians, residents, fellows, and nurses as dismissive or disrespectful. Individuals noted that, in most cases when reported, these behaviors appeared to improve.

In the group interviews with the program directors, 92% expressed the belief that MUSC is usually or always effective in managing reports of unprofessional behavior.

The group discussions concluded by exploring attitudes and beliefs regarding options for dealing with potential mistreatment. The CLER team presented the residents and fellows with a scenario describing an attending physician's mistreatment of a resident colleague. In the scenario, the issues of mistreatment continue to persist although reported to the chief resident, program director, department chair, and head of GME. When presented with several options for what they would advise the colleague to do next, residents and fellows responded as follows: 55%, contact the human resources (HR) department or the medical center's hotline; 14%, contact the Equal Employment Opportunity Commission (EEOC); 18%, register a concern with the ACGME; and 11%, "other." Of those who responded "other," some indicated that they would advise repeating the process through GME or approaching the university ombudsman or going to the diversity office.

When presented with the same scenario, 52% of the program directors and 40% of the faculty members in the group interviews expressed the belief that the resident would contact the HR department or the medical center's hotline; 18% of the faculty members and 28% of the program directors selected "other." Of these, some expressed the belief that the resident would return to the program director, approach a faculty mentor, speak to an attorney, or report the behavior through the patient safety event reporting system.
In closing, the CLER Program would like to thank the Medical University of South Carolina Medical Center for its hospitality in facilitating the visit. We recognize that a great deal of effort went into making the arrangements. We hope that the observations made during this visit are helpful to you in identifying opportunities for improving patient care and education of residents and fellows. We invite you to share your comments about the site visit process and/or your plans to use this information on the optional response form included with this report. We look forward to visiting you again in the future.

Note. The CLER Program is designed to broadly inform the ACGME Accreditation System. CLER visits do not result in citations or directly lead to programmatic or institutional accreditation decisions. CLER staff/volunteers may share CLER-derived data/information with the Institutional Review Committee, the ACGME Residency Review Committees, or the public only in de-identified or aggregate form, unless written permission is obtained from the DIO of the Sponsoring Institution.
From: c Gillard@acgme.org
Sent: Wednesday, October 03, 2018 4:22 PM
To: Gregg, David
Cc: Clyburn, Ernest Benjamin; Adams, Anna; Ybarra, Angela; Ronayne, Ann; Clyburn, Ernest Benjamin; Judge, Daniel; WEBADS@acgme.org
Subject: ACGME - Meeting Decision

CAUTION: External

Dear Dr. Gregg,

In accordance with the ACGME's Next Accreditation System and the policies set forth in its Policies and Procedures Manual, all accredited programs are being reviewed annually by their relevant Review Committee. At its 09/28/2018 meeting, the Review Committee for Internal Medicine reviewed the program listed below and took the following action:

Adult congenital heart disease

1534514001 - Medical University of South Carolina Program

Initial Accreditation
Total Accredited Residents: 1

New Status:
Total Combined Positions: 0
Effective Date: 07/01/2018

A detailed letter of notification will be posted in the ACGME Accreditation Data System (ADS) within 60 days of this e-mail, and you will be notified by e-mail when the letter is available. Until the official letter is posted in ADS, Review Committee staff members cannot discuss the Committee's action. When you receive the letter, please contact the Executive Director if you require further clarification regarding the content of the letter or status of your program.

ADS is accessible at the following address - https://apps.acgme.org/ads. For any technical issues with ADS, please contact WEBADS@acgme.org.

Sincerely,

Christine Gillard

Accreditation Administrator
Dear Dr. Newbrough,

In accordance with the ACGME's Next Accreditation System and the policies set forth in its Policies and Procedures Manual, all accredited programs are being reviewed annually by their relevant Review Committee. At its 09/28/2018 meeting, the Review Committee for Internal Medicine reviewed the program listed below and took the following action:

Geriatric medicine (Internal medicine)

1514514120 - Medical University of South Carolina Program

Initial Accreditation
Total Accredited Residents: 2
Total Combined Positions: 0
Effective Date: 07/01/2018

A detailed letter of notification will be posted in the ACGME Accreditation Data System (ADS) within 60 days of this e-mail, and you will be notified by e-mail when the letter is available. Until the official letter is posted in ADS, Review Committee staff members cannot discuss the Committee's action. When you receive the letter, please contact the Executive Director if you require further clarification regarding the content of the letter or status of your program.

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Sincerely,

Christine Gillard

Accreditation Administrator
CAUTION: External

ACGME - Meeting Decision

Dear Dr. Kilb,

In accordance with the ACGME's Next Accreditation System and the policies set forth in its Policies and Procedures Manual, all accredited programs are being reviewed annually by their relevant Review Committee. At its 09/28/2018 meeting, the Review Committee for Internal Medicine reviewed the program listed below and took the following action:

Critical care medicine (Internal medicine)

1424514001 - Medical University of South Carolina Program

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Sincerely,

Christine Gillard

Accreditation Administrator
8/9/2018

George B Whitener, MD
Associate Professor
Medical University of South Carolina
167 Ashley Avenue, Suite 301
MSC 912
Charleston, SC 29425

Dear Dr. Whitener,

The Review Committee for Anesthesiology, functioning in accordance with the policies and procedures of the Accreditation Council for Graduate Medical Education (ACGME), has reviewed the information submitted regarding the following program:

Adult cardiothoracic anesthesiology

Medical University of South Carolina Program
Medical University of South Carolina College of Medicine
Charleston, SC

Program 0414531020

OTHER COMMENTS

On behalf of the Anesthesiology Review Committee (RC), I'd like to congratulate you on your new position, wish you good luck with your new responsibilities, and thank you for your commitment to graduate medical education.

The Anesthesiology RC has reviewed your CV and finds that your qualifications meet those included in the program requirements for Adult Cardiothoracic Anesthesiology programs. The Committee has no reservations with your appointment and is confident that the transition will be successful.

Please feel free to contact me if I can ever be of assistance. Again, congratulations on your new role.

This office must be notified of any major changes in the organization of the program. When corresponding with this office, please identify the program by name and number as indicated above. Changes in participating sites and changes in leadership must be reported to the Review Committee using the ACGME Accreditation Data System.
Sincerely,

Anne Gravel Sullivan, PhD
Executive Director
Review Committee for Anesthesiology
312.755.7032
asullivan@acgme.org

CC: Ernest B. Clyburn, MD
    George J. Guidan III, MD

Participating Site(s):
### Program Name: Developmental and Behavioral Peds

<table>
<thead>
<tr>
<th>Overall Attrition</th>
<th>Resident Survey</th>
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### Data Omission

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### Scholarly Activity

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Program Name: Developmental and Behavioral Peds

Excellent Board take and pass rate

Are you working on formal criteria for handoffs? We understand that most occur via phone, but there should be a formal criteria

Good wellness curriculum

Can't just skip the question on your program's AIMS - must fill that in (will use it for self studies)

MUSC must have secure area for residents

In the CVs, no reason to list out headers for chapters/textbooks, grants/presentations/etc...

Does Dr. Spratt plan on taking the Peds boards?

Good scholarly activity for faculty and residents

Faculty survey very good, with improvements over the previous year

Good action plan with measurable items
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Program Name: Rheumatology

Excellent Board pass and take rate

Immunology rounds is a nice example of a collaborative effort created to address an issue previously identified

Good faculty scholarly activity. Fellows appropriately give conferences, teach and conduct research

Dr. Hant has let her IM certification lapse - any plans to retake those boards? Did she retake Rheum board in 2017?
Dr. Hant has out of date bibliography entries

In the Action Plan, metrics for immunology rounds should be SITE exam results or a more specific indicator of medical knowledge
Similarly for MSK U/S

While the resident survey is good and above the national mean in all categories, results dropped a bit from last year

GME Stewardship - VA Time Tracking reports are consistently late and the APE was not turned in on time
Excellent board take and pass rate
Good descriptions of strengths and weaknesses on internal survey

Dr. Titus' CV lists expiration on 10/17 for licensure - needs updating
Should she have recertified in 2016? If so, needs updating on her CV and in the listing of faculty/teaching staff PD Information
Same for all faculty on the roster that were certified in 2005, 2006, etc...
Under activities on the CV, take away numbers - take away differences between platform and poster presentations
Scholarly activities met for both faculty and residents
For Q22 - you have not answered how you will be improving faculty mentoring and support for trainees, as mentioned in Q21, nor how you are encouraging healthy lifestyles

At or above the national mean in all content areas on faculty survey
Just below national mean in educational content on resident survey. All other areas are at or above national mean
As mentioned in the APE, this is largely driven by "provided data about practice habits" and "see patients across variety of settings"

Good action plan, addressing weaknesses of both internal and ACGME surveys. Needs an action item on seeing patients across settings

Pediatrics and its' sub-specialties may want to present at a GMEC about how they are all working together in beginning the self-study process
### Program Name: Geriatric Psychiatry

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#### Resident Survey
- **Duty Hours**: N/A
- **Faculty**: N/A
- **Educational Content**: N/A
- **Evaluation**: N/A
- **Resources**: N/A
- **Patient Safety/Teamwork**: N/A

#### Faculty Survey
- **Supervision & Teaching**: N/A
- **Educational Content**: N/A
- **Resources**: N/A
- **Patient Safety**: N/A
- **Teamwork**: N/A

#### Number of subspecialties with 3 or more indicators flagged
- **Overall Negative Opinion**: N/A

#### Involvement in QI/Pt Saf Projects
- **Number of subspecialties with 3 or more indicators flagged**: N/A

#### GME Stewardship
- **Involvement in QI/Pt Saf Projects**: N/A
Program Name: Geriatric Psychiatry

There is not an attrition problem, rather, the problem is in recruiting residents. Glad to see that there are people recruited for the 19-20 year
Board pass rate is good, although take rate is only at 80%
You must make sure that core faculty remain interested in faculty development
There must be secured areas at the VAMC for residents to store their personal items
No ACGME survey data available
Good action plan for next year when you do have residents in place
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<td>Failure to turn in APE materials</td>
<td>Resident</td>
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</table>

Page 1 of 2
Program Name: Cytopathology

Small fellowship - minimal reporting data from the fellows. Would be helpful to send a postgraduate survey to help guide improvements.

Excellent board pass rate, although your take rate is at 80%
Good plan to address the AFI and fellow research

Does Dr. Yang spend more time with residents than the program director? It's indicated that he spends 30 hours per week, as compared to Dr. Chajewski's 20 hours
Do path faculty have to renew the certification every 10 years? If so, should they physician roster be updated
In bibliography take away the numbered bullet points
Excellent faculty scholarly activity
Q22 doesn't answer how you propose to address workload or encourage healthy lifestyle

At or above national mean in all areas of content in the ACGME faculty survey

Action plan addresses concern from the current fellows - this is where the aforementioned postgraduate survey may be helpful
<table>
<thead>
<tr>
<th>Program Name: Hematopathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attrition</td>
</tr>
<tr>
<td>Scholarly Activity</td>
</tr>
<tr>
<td>Board Pass Rate</td>
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<tr>
<td>Resident Survey</td>
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<td>Faculty Survey</td>
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<tr>
<td>Opinion</td>
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<td>Subspecialties</td>
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<tr>
<td>MISC Indicators</td>
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<tr>
<td>Action Plan</td>
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<tr>
<td>QI/Patient Safety</td>
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<tr>
<td>GME Stewardship</td>
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</tbody>
</table>

### Overall Attrition
- PD Change
- Faculty Attrition
- Resident Attrition
- Permanent Complement Changes

### Resident Survey
- 100% completed
- Duty Hours
- Faculty
- Educational Content
- Evaluation
- Resources
- Patient Safety/Teamwork

### Faculty Survey
- 100% completed
- Supervision & Teaching
- Educational Content
- Resources
- Patient Safety
- Teamwork

### Data Omission
- Failure to complete WEBADS annual update (on time)
- Failure to turn in APE materials

### Scholarly Activity
- Faculty
- Resident

### Number of subspecialties with 3 or more indicators flagged
- N/A

### Action Plan

### Board Pass Rate

### Involvement in QI/Pt Saf Projects

### GME Stewardship
Program Name: Hematopathology

Small fellowship - minimal reporting data for the fellows. Would be helpful to send a postgraduate survey to help guide improvements.

Excellent board pass rate

The AFI for lack of research is well addressed in the major changes section and action plan - but remember that speaking at conferences, giving lectures, etc... are important ways to meet this goal as well.

Is Dr. Lazarchick's certification status O or should it be N - time unlimited certificate/no Re-Certification

Under his bibliography and participation, take out numbered bullets

Excellent scholarly activity by faculty and adequate for fellow

Q22 doesn't answer how your program is now encouraging a healthy lifestyle

Good action plan
Medical University of South Carolina - 10-8-18
Duty Hours Violations report: 80 Hours Per Week - Averaged Over A Four-Week Period
Reporting Period: 07/01/2018 through 06/30/2019 (365 days)

Maximum hours: 320 hours in 28 days (4 week)

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<tr>
<th>Obstetrics and Gynecology</th>
<th>Hours Per Week</th>
<th>Rotation Start</th>
<th>Rotation End</th>
<th>Hours Worked</th>
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